

Managing Pregnancy and Bipolar Disorder

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Women with chronic medical illnesses, including bipolar disorder, often desire to have children but are concerned about the impact of a pregnancy on their illness and about the potential effects of the medications that they take on their child. In a recent issue of the *American Journal of Psychiatry*, researchers summarized what is known from the research literature about this important issue.¹ Their findings are summarized below.

Because bipolar disorder emerges during young adulthood and persists throughout the lifespan, women of childbearing age are at risk for this illness. Pregnancy and delivery can influence the symptoms of bipolar disorder: pregnant women or new mothers with bipolar disorder have a sevenfold higher risk of hospital admission and a twofold higher risk for a recurrent episode, compared with those who have not recently delivered a child or are not pregnant.

Careful planning for pregnancy can help women with bipolar disorder optimally manage their illness to minimize their symptoms and avoid risks to the fetus. Experts suggest it is important to avoid sudden changes in medication during pregnancy, because such changes may increase side effects and risks to the fetus, and also increase the risk of relapse of the illness before or after the woman gives birth.

A review of research about various medications used in bipolar disorder led researchers to the following conclusions: Lithium and first-generation antipsychotics (e.g. Haldol, Thorazine) are preferred mood stabilizers because they consistently show minimal risks to the fetus. Some anticonvulsants (e.g., Depakote and Tegretol) have been proven harmful to fetuses, possibly contributing to birth defects. Studies show that exposure to only one mood stabilizing medication is less harmful to the developing fetus than exposure to multiple medications. Some details concerning specific medications are listed below.

Lithium

For many people, lithium is a mainstay of their treatment for bipolar disorder. The decision to continue taking lithium during pregnancy can be life saving to the mother. Other women might switch to lithium because it has fewer risks to the developing fetus than their current medication. While taking lithium, it is important that women stay hydrated to prevent lithium toxicity in themselves and the fetus. Careful monitoring of lithium levels, especially during delivery and immediately after birth, can help prevent a relapse in the mother and will also show if there are high lithium levels in the infant.

Lithium is the only drug proven to reduce the rate of relapse of illness from nearly 50 percent to less than 10 percent when women continue or begin lithium treatment after giving birth. Women who choose to breast-feed should know that lithium is secreted in breast milk. Breast-fed newborns whose mothers take lithium should have their blood monitored for lithium.

Depakote

Since Depakote is a substance proven to have harmful effects on fetuses, many experts recommend that women switch to another mood stabilizer before conception. However, half of all women do not plan their pregnancies, and those taking Depakote who later become pregnant must weigh the risks and benefits of continuing this treatment. If a woman decides to continue taking Depakote, a single daily dose can be more harmful than separate doses. Experts recommend that doses of less than 1000 mg/day be taken in divided doses. It is recommended that women continuing Depakote also take vitamin K to help prevent conditions that affect the infant's head and face.

¹ Yonkers, K.A., Wisner, K.L., Stowe, Z., Leibenluft, E., Cohen, L., & Miller, L., et al. (2004). Management of bipolar disorder during pregnancy and the postpartum period *American Journal of Psychiatry*, 161, 608-620.

No adverse effects have been reported among infants whose mothers were treated with Depakote. The American Academy of Neurology and the American Academy of Pediatrics agree that Depakote is compatible with breast-feeding.

Tegretol

Most experts feel that Tegretol should only be used during pregnancy if there are no other options. However, an unplanned pregnancy may not be discovered until after the risk period for the harmful effects of Tegretol has already passed. For women who choose to continue therapy with Tegretol, vitamin K should be taken to promote mid-facial growth and the formation of proper blood clotting factors in fetuses.

It is important to note that women who start taking Tegretol *after* conception incur more risk of serious side effects (such as rare blood disorder and liver failure) than women receiving treatment with Tegretol at the time of conception. Concentrations of Tegretol in breast milk were low when measured in women who took this medication during pregnancy. The American Academy of Neurology and the American Academy of Pediatrics agree that Tegretol is compatible with breast-feeding.

First-Generation Antipsychotic Medications

First-generation antipsychotic medications continue to play a major role in the acute treatment of mania. Since they have a longer history of use than many mood stabilizers, their effect on pregnant women is better documented. Some health care professionals suggest that a woman's medication be switched from lithium or an anticonvulsant to a first-generation antipsychotic medication for either the entire pregnancy or the first trimester. The switch appears to be especially beneficial for women who have benefited from mood stabilization with these medications in the past. First-generation antipsychotic medications may also be useful to women who elect to stop medication therapy during pregnancy but experience a recurrence of symptoms while pregnant. Though studies are small, no adverse effects have been noted in the majority of cases where women take first-generation antipsychotic medications and breast-feed.

Second-Generation Antipsychotic Medications

Few studies have been reported on the use of second-generation medications during pregnancy. Several second-generation antipsychotic medications have not yet been approved for maintenance therapy for bipolar disorder, including Seroquel (quetiapine) and Risperdal (risperidone). Early studies indicate that Zyprexa (olanzapine), which has been approved by the Food and Drug Administration (FDA) for the treatment of acute mania, is not associated with birth defects. However, Zyprexa has been associated with weight gain, gestational diabetes, and high blood pressure. Weight gain, blood sugar levels, and blood pressure should be monitored carefully in all pregnant women taking Zyprexa.

Tranquilizer and Sedative Medications

Difficulty sleeping and anxiety are powerful triggers for the recurrence of episodes in bipolar disorder. Tranquilizers and sedatives, which help to regulate sleep, may reduce the risk of episodes during or after pregnancy. Medications that stay in the body the least amount of time are preferred. Sedatives and hypnotics are excreted in breast milk, but there have been few reports of complications due to their use.

Electroconvulsive Therapy (ECT)

When used in women who are pregnant, ECT may pose fewer risk than untreated mood episodes or treatment with medications known to be harmful to fetuses. Complications of ECT during pregnancy are uncommon. Monitoring heart rate and oxygen levels of the fetus during ECT can detect most problems, and medications are available to correct difficulties. Though some birth defects, developmental delays, or mental retardation have been described in the children of women who underwent ECT while pregnant, there is not a number or pattern to these reports that suggests a relationship to ECT. It is very important for pregnant women who undergo ECT to stay nourished and hydrated to help prevent premature contractions. Intubation or antacids may also be used to decrease the risk of gastric regurgitation or lung inflammation during anesthesia for ECT.

Psychosocial Interventions

Though little research has been done on the direct or indirect effects of non-pharmacological treatments, it is widely believed that therapy can help improve functioning in social and occupational settings, minimize loss of sleep (which often precipitates mania), and help prevent relapses. Structured daily activities, which help minimize sleep deprivation and reduce rapid shifts in moods, are very important during pregnancy.

In conclusion, there is clearly a need for more research on bipolar disorder treatment during and after pregnancy. Women with bipolar disorder who want to have children should work together with their health care providers to identify the best options for them. Information and careful planning are the keys to successfully managing bipolar disorder both during and after pregnancy.

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